Family Medicine Residency Program
Department of Family Medicine and Emergency Medical Services
1 Jarrett White Road
Honolulu, Hawai'i 96859-5000

Information Packet
Veterans Affairs Center for Aging Rotation

In addition to those requirements outlined in the goals and objectives for this rotation, the following are additional requirements for this rotation and need to be completed and turned into the Residency Administrative Assistant as soon as possible but ***no later than 1 August*** of academic year that you will be doing this rotation. Items 2 through 7 are included in this packet.

1. A ***copy*** of your current permanent or temporary Hawai'i license. ***Out of state license not acceptable for this rotation***.
2. Completion of Veterans Affairs Form 10-2850b, Application for Residents.
3. Completion of Optional Form 306, Declaration for Federal Employment.
4. Completion of Veterans Affairs Form 10-0410, Clinical Trainee Registration Form.
5. Completion of Department of Homeland Security Form I-9, Employment Eligibility Verification.
6. Completion of Attachment A, Automated Information Systems Access Agreement.
7. Completion of Attachment B, Request for VHA LAN/VistA Access. Complete date and from and items 1 through 8.
8. Completion of VA Cyber Security Awareness [https://www.ees-learning.net/] training. After the initial log-in select the highlighted "FIRST TIME USER" button where course registration occurs. At the end of the training, print certificate of completion and submit with above forms.

Approved Exception To SF 171
OMB No. 2900-0205
Estimated burden: 30 minutes
Expiration Date: 3/31/2006

Department of Veterans Affairs

APPLICATION FOR RESIDENTS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER.

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. NAME (Last, First, Middle)	2. APPLICATION FOR (Check one) ☐ GENERAL PRACTICE ☐ SPECIALTY (Identify below)
3. PRESENT ADDRESS (Include ZIP Code)	4. TELEPHONE NUMBER (Include Area Code)
	4A. RESIDENCE / 4B. BUSINESS

5. DATE OF BIRTH	6. PLACE OF BIRTH	7. SOCIAL SECURITY NUMBER
8A. CITIZENSHIP ☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete Item 8B)		8B. COUNTRY OF WHICH YOU ARE A CITIZEN
9. DESIRED STARTING DATE OF RESIDENCY	10. ARE YOU A PARTICIPANT IN THE CURRENT NATIONAL RESIDENT MATCHING PROGRAM ☐ YES ☐ NO	
11A. ARE YOU A DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS ☐ YES ☐ NO (If "YES" complete items 11B and 11C)	11B. NUMBER OF DIPLOMA	11C. DATE OF DIPLOMA

NOTE: Complete item 12A, 12B, 12C, or 12D, ONLY if you are not a U.S. Citizen.

12A. IMMIGRANT	12B. EXCHANGE VISITOR		12C. OTHER NON-IMMIGRANT		12D. FORM IAP-66
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID FORM IAP-66 ☐ YES ☐ NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION

I - ACTIVE U.S. MILITARY DUTY

13A. DATE FROM	13B. DATE TO	13C. SERIAL OR SERVICE NO.	13D. BRANCH OF SERVICE	13E. TYPE OF DISCHARGE ☐ HONORABLE ☐ OTHER (Explain on separate sheet)

II - LICENSURE, DEA CERTIFICATION AND CLINICAL PRIVILEGES

14A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED (If not held now, explain on separate sheet)	14B. LICENSE NO.	14C. CURRENT REGISTRATION (If "NO" explain on separate sheet) YES	NO	NOT REQUIRED	14D. EXPIRATION DATE
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	

15. DO YOU HAVE OR HAVE YOU EVER HAD ANY LICENSE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED OR ISSUED/PLACED IN A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED ☐ YES ☐ NO (If "YES" explain on separate sheet)	16A. NUMBER OF CURRENT OR MOST RECENT DEA (DRUG ENFORCEMENT ADMINISTRATION) CERTIFICATE	16B. DATE OF EXPIRATION	17. HAVE YOU EVER HAD A DEA CERTIFICATE REVOKED, SUSPENDED, LIMITED, RESTRICTED IN ANY WAY OR VOLUNTARILY RELINQUISHED ☐ YES ☐ NO (If "YES" explain on separate sheet)
18A. DO YOU CURRENTLY HAVE OR HAVE YOUEVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY ☐ YES ☐ NO (If "YES" complete Item 18B)	18B. NAME AND ADDRESS OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD		18C. HAVE ANY OF YOUR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, NOT RENEWED, OR VOLUNTARILY RELINQUISHED ☐ YES ☐ NO (If "YES" explain on separate sheet)

III - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

▶ **CERTIFICATION:** **I certify that I have verified licensure and registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate).**

19. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:		
NATURALIZED CITIZENSHIP	FULL LICENSURE / REGISTRATION	OR
VISA	ECFMG CERTIFICATION	RESIDENT CREDENTIAL VEREFICATION LETTER
	CLERKSHIPS TAKEN IN THE U.S.	

20A. SIGNATURE OF FACILITY DIRECTOR OR DESIGNEE	20B. TITLE	20C. DATE

IV - PROFESSIONAL LIABILITY INSURANCE

21A. PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER	21B. DATE COVERAGE BEGAN	21C. NAME OF PRIOR CARRIERS	21D. DATES OF COVERAGE FROM	21D. DATES OF COVERAGE TO	22. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE ☐ YES ☐ NO (If "YES" explain on separate sheet)

V - MEDICAL/DENTAL SCHOOLS ATTENDED

23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP Code)	23C. SUBJECT/ MAJOR	23D. YEARS ATTENDED	23E. GRADUATED MONTH	23E. GRADUATED YEAR	23F. DEGREE

24. IF YOU ARE NOT A UNITED STATES OR CANADIAN MEDICAL/DENTAL SCHOOL GRADUATE, HAVE YOU SUCCESSFULLY COMPLETED THE REQUIREMENTS OF A MEDICAL/DENTAL EDUCATION EQUIVALENCY PROGRAM (e.g., examination or "Fifth Pathway"). (If "YES", indicate name of program, date completed, and if applicable, certificate number, plus whether permanent or interim.)

☐ YES ☐ NO

NOTE: If you are not a United States or Canadian medical/dental school graduate, list on a separate sheet all clinical clerkships you have served, with institution (name and address), inclusive dates of service, program type, and program contact for each clerkship.

NOTE: For items 25 through 28, specify when service was as a paid Federal employee, including the VA, the U.S. Military, and the Public Health Service.

VI - DENTAL GENERAL PRACTICE RESIDENCIES

25A. NAME OF HOSPITAL	25B. ADDRESS (City, State and ZIP Code)	25C. DATE COMPLETED	25D. NO. OF MONTHS

VII - SPECIALTY/SUBSPECIALTY RESIDENCIES

26A. NAME OF HOSPITAL OR INSTITUTION (or military assignment and rank)	26B. ADDRESS (City, State and ZIP Code)	26C. SPECIALTY/ SUBSPECIALTY	26D. TRAINING COMPLETED MONTH	26D. TRAINING COMPLETED YEAR	26E. NO. OF MONTHS SERVED	26F. AMOUNT OF TIME APPROVED BY SPECIALTY BOARD

27A. HAVE YOU EVER SERVED AS AN ADMINISTRATIVE CHIEF RESIDENT ☐ YES ☐ NO	27B. DATES OF SERVICE

VIII - PROFESSIONAL EXPERIENCE (IN OTHER THAN MEDICAL/DENTAL TRAINEE STATUS)

28A. EMPLOYER	28B. ADDRESS (City, State and ZIP Code)	28C. POSITION (Where applicable also specify whether General Practitioner or Specialist)	28D. FULL TIME	28E. PART-TIME (average hours per week)	28F. DATES EMPLOYED FROM	28F. DATES EMPLOYED TO
			☐	☐		
			☐	☐		
			☐	☐		

IX - THIS SECTION TO BE COMPLETED BY APPROPRIATE COMMITTEE OR DESIGNATED OFFICIAL

HOUSE STAFF REVIEW COMMITTEE

31A. REMARKS	31B. CHAIRPERSON'S APPROVAL OF GENERAL QUALIFICATIONS	31C. DATE
	Dr. Steven MacBride	

DEANS COMMITTEE OR MEDICAL ADVISORY COMMITTEE

32A. RECOMMENDED FOR	32B. POST GRADUATE LEVEL RECOMMENDED	32C. LEVEL OF VACO APPROVAL REQUIRED	32D. APPLICANT/APPOINTEE MEETS ALL REQUIREMENTS AND REGULATIONS FOR APPOINTMENT OF HOUSE STAFF
CHIEF RESIDENT	1ST YR. 2ND YR.		
RESIDENCY IN:	3RD YR. 4TH YR. 5TH YR.	LEVEL 6 LEVEL 7	YES NO

32E. REMARKS	32F. SIGNATURE OF CHAIRPERSON OR DESIGNEE	32G. DATE
	Dr. Steven MacBride	

FINAL APPROVAL	33A. VA FACILITY	33B. NAME OF AFFILIATED MEDICAL OR DENTAL SCHOOL	33C. DATE OF APPOINTMENT
	33D. REMARKS	33E. SIGNATURE OF FACILITY DIRECTOR Dr. James. E. Hastings, Director	33F. DATE

X - GENERAL INFORMATION

29. NAMES UNDER WHICH YOU WERE EMPLOYED, IF DIFFERENT FROM NAME GIVEN IN ITEM 1

30. LIST ALL PROFESSIONAL PUBLICATIONS, SCIENTIFIC PAPERS, HONORS, AWARDS, RESEARCH GRANTS AND FELLOWSHIPS (If additional space is required, attach separate sheet).

ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET OF PAPER	YES	NO
34.	Do you receive or do you have a pending application for retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia service?	☐	☐
35.	Does the Department of Veterans Affairs employ any relative of yours (by blood or marriage)? If "YES" give separately such relative's (1) full name; (2) relationship; (3) VA position and employment location.	☐	☐
36.	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? (If "YES" give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.) (As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proven groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.)	☐	☐

NOTE: A conviction or a discharge does not necessarily mean you cannot be appointed. The nature of the conviction or discharge and how long ago it occurred is important. Give all the facts so that a decision can be made. If your answer to question 39, 40 or 41 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 39 or 40, you may omit (1) traffic fines for which you paid a fine of $100.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.

37.	Within the last five years have you been discharged from any position for any reason?	☐	☐
38.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?	☐	☐
39.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.)	☐	☐
40.	During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in 39 above?	☐	☐
41.	While in the military service were you ever convicted by a general court-martial?	☐	☐
42.	If you were in the military service as a physician, dentist, podiatrist or optometrist, did you ever receive a non-judicial punishment (Article 15)?	☐	☐
43.	Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student and home mortgage loans.) If "Yes" explain on a separate sheet the type, length, and amount of the delinquency or default and steps you are taking to correct errors or repay the debt. Give any identification numbers associated with the debt and the address of the Federal agency involved.	☐	☐

XI - SIGNATURE OF APPLICANT

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

Una

CERTIFICATION: **I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.**

44A. SIGNATURE OF APPLICANT (Sign in dark ink)	44B. DATE (Month, Day, Year)

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

☐ Authorize the VA to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom the VA may be referred by those contacted or deemed appropriate;

☐ Authorize release of such information and copies of related records and/or documents to VA officials;

☐ Release from liability all those who provide information to the VA in good faith and without malice in response to such inquiries; and

☐ Authorize the VA to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable the VA to make such inquiries.

SIGNATURE	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

AUTHORITY: The information requested on the attached application form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for employment. If you are employed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

ROUTINE USES: Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State or local agency, to the National Practitioner Data Bank which is administered by the Department of Health and Human Services, to State licensing boards, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for hiring and for employment, to periodically verify, evaluate and update your clinical privileges and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may also be released without your prior consent to Federal agencies, State licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to State licensing boards and the National Practitioner Data Bank. The information you supply may be verified through a computer matching program at any time.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Disclosure of the other information is voluntary; however, failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from your former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

Instructions

The information collected on this form is used to determine your acceptability for Federal and Federal contract employment and your enrollment status in the Government's Life Insurance program. You may be asked to complete this form at any time during the hiring process. Follow instructions that the agency provides. If you are selected, before you are appointed you will be asked to update your responses on this form and on other materials submitted during the application process and then to recertify that your answers are true.

All your answers must be truthful and complete. **A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you, or for firing you after you begin work. Also, you may be punished by a fine or imprisonment (U.S. Code, title 18, section 1001).**

Either type your responses on this form or print clearly in dark ink. If you need additional space, attach letter-size sheets (8.5" x 11"). Include your name, Social Security Number, and item number on each sheet. We recommend that you keep a photocopy of your completed form for your records.

Privacy Act Statement

The Office of Personnel Management is authorized to request this information under sections 1302, 3301, 3304, 3328, and 8716 of title 5, U.S. Code, Section 1104 of title 5 allows the Office of Personnel Management to delegate personnel management functions to other Federal agencies. If necessary, and usually in conjunction with another form or forms, this form may be used in conducting an investigation to determine your suitability or your ability to hold a security clearance, and it may be disclosed to authorized officials making similar, subsequent determinations.

Your Social Security Number (SSN) is needed to keep our records accurate, because other people may have the same name and birth date. Public Law 104-134 (April 26, 1996) asks Federal agencies to use this number to help identify individuals in agency records. Giving us your SSN or any other information is voluntary. However, if you do not give us your SSN or any other information requested, we cannot process your application. Incomplete addresses and ZIP Codes may also slow processing.

ROUTINE USES: Any disclosure of this record or information in this record is in accordance with routine uses found in System Notice OPM/GOVT-1, General Personnel Records. This system allows disclosure of information to: training facilities; organizations deciding claims for retirement, insurance, unemployment, or health benefits; officials in litigation or administrative proceedings where the Government is a party; law enforcement agencies concerning a violation of law or regulation; Federal agencies for statistical reports and studies; officials of labor organizations recognized by law in connection with representation of employees; Federal agencies or other sources requesting information for Federal agencies in connection with hiring or retaining, security clearance, security or suitability investigations, classifying jobs, contracting, or issuing licenses, grants, or other benefits; public and private organizations, including news media, which grant or publicize employee recognitions and awards; the Merit Systems Protection Board, the Office of Special Counsel, the Equal Employment Opportunity Commission, the Federal Labor Relations Authority, the National Archives and Records Administration, and Congressional offices in connection with their official functions; prospective non-Federal employers concerning tenure of employment, civil service status, length of service, and the date and nature of action for separation as shown on the SF 50 (or authorized exception) of a specifically identified individual; requesting organizations or individuals concerning the home address and other relevant information on those who might have contracted an illness or been exposed to a health hazard; authorized Federal and non-Federal agencies for use in computer matching; spouses or dependent children asking whether the employee has changed from a self-and-family to a self-only health benefits enrollment; individuals working on a contract, service, grant, cooperative agreement, or job for the Federal government; non-agency members of a agency's performance or other panel; and agency-appointed representatives of employees concerning information issued to the employees about fitness-for-duty or agency-filed disability retirement procedures.

Public Burden Statement

Public burden reporting for this collection of information is estimated to vary from 5 to 30 minutes with an average of 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to the U.S. Office of Personnel Management, Reports and Forms Manager (3206-0182), Washington, DC 20415-7900. The OMB number, 3206-0182, is valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

GENERAL INFORMATION

1 FULL NAME *(First, middle, last)*

▶

2 SOCIAL SECURITY NUMBER

▶

3 PLACE OF BIRTH *(Include City and State or Country*

▶

4 DATE OF BIRTH *(MM/DD/YY)*

▶

5 OTHER NAMES EVER USED *(For example, maiden name, nickname, etc.)*

▶

▶

6 PHONE NUMBERS *(Include Area Codes)*

DAY ▶

NIGHT ▶

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO *If "NO" skip 7b and 7c. If "YES" go to 7b.*

7b. Have you registered with the Selective Service System? ☐ YES ☐ NO *If "NO" go to 7c.*

7c. If "NO," describe your reason(s) in item #16.

Military Service

8. Have you ever served in the United States military? ☐ YES *Provide information below* ☐ *NO*

If you answered "YES," list the branch, dates, and type of discharge for all active duty.
If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From *MM/DD/YYYY*	To *MM/DD/YYYY*	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each even you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9, 10, and 11, your answers should include convictions resulting from a plea *nolo contendere* (no contest), but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law.

9. During the last 10 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* YES ☐ NO ☐

10. Have you been convicted by a military court-martial in the past 10 years? *(If no military service, answer "NO." If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.* YES ☐ NO ☐

11. Are you now under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* YES ☐ NO ☐

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? *If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.* YES ☐ NO ☐

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.* YES ☐ NO ☐

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name, relationship, and the department, agency, or branch of the Armed Forces for which your relative works.* YES ☐ NO ☐

15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service? YES ☐ NO ☐

Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed *(these questions are specific to your position and your agency is authorized to ask them).*

Certifications / Additional Questions

APPLICANT: ***If you are applying for a position and have not yet been selected,*** carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

APPOINTEE: ***If you are being appointed,*** carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. **I certify** that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. **I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand** that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date

17a Applicant's Signature ▶ _____ *(Sign in ink)* Date ▶ _____

17b Appointee's Signature ▶ _____ *(Sign in ink)* Date ▶ _____

Appointing Officer:
Enter Date of Appointment or Conversion
MM/DD/YYYY
▶

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

MM/DD/YYYY

18a. When did you leave your last Federal job? DATE:

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? YES ☐ NO ☐ Do Not Know ☐

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. YES ☐ NO ☐ Do Not Know ☐

Department of Veterans Affairs

CLINICAL TRAINEE REGISTRATION FORM

Response is mandatory. This information will be kept confidential. It will be used for reporting purposes, conducting surveys, and improving the quality of VHA's clinical training programs. This information will be entered in the "New Person" file in Veterans Health Information Systems and Technology Architecture (VistA). This form may also be printed from the OAA website: http://vaww.va.gov/oaa/policies.asp

Disclosure of your Social Security Number (SSN) is mandatory to identify individuals with identical names. Failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining clinical training at VA. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The information gathered through the use of this number will be used as necessary for statistical studies and personnel administration in accordance with established regulations and published notices of systems of record.

First Name	MI	Last Name

Social Security Number	Home Email Address

Street Address 1

Street Address 2

Street Address 3

City	State	Zip

Current Degree Level: *(mark only one)*

- O Certificate/Diploma
- O Associate
- O Baccalaureate
- O Master's
- O Post-master's fellowship
- O Doctoral
- O Postdoctoral (other than residents)
- O Residency/Fellowship

Program of Study: *(mark only one)*
(Discipline that best describes the current program of study

- O Audiology
- O Chaplaincy
- O Dentistry
- O Dietetics
- O Health Information
- O Health Services Research & Development
- O Imaging (Radiologic/Ultrasound Tech, etc.)
- O Laboratory
- O Medical Student
- O Medical Resident/Fellow
- O Medical Post-residency Physician in a VA Special Fellowship (Ambulatory Care, National Quality Scholars, Women's Health, etc.)
- O Medical/Surgical Support (Respiratory Tech, Biomedical Tech, etc.)
- O Nurse Anesthetist
- O Nursing
- O Optometry
- O Other
- O Pharmacy
- O Physician Assistant
- O Podiatry
- O Psychology
- O Rehabilitation (OT, PT, KT, etc.)
- O Social Work
- O Speech–Language Pathology

What is the LAST YEAR that you anticipate being in a training program at this VA facility?

O 2003 O 2004 O 2005
O 2006 O 2007 O 2008

Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 03/31/07

Employment Eligibility Verification

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1- Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1)** document title; **2)** issuing authority; **3)** document number, **4)** expiration date, if any; and **5)** the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, 5 minutes; **2)** completing the form, 5 minutes; and **3)** assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachuetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 03/31/07

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien #) A _____
- ☐ An alien authorized to work until _____

(Alien # or Admission #) _____

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date *(if any)*: _____		_____		_____
Document #: _____				
Expiration Date *(if any)*: _____				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.
Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

LISTS OF ACCEPTABLE DOCUMENTS

LIST A

Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship *(Form N-560 or N-561)*
3. Certificate of Naturalization *(Form N-550 or N-570)*
4. Unexpired foreign passport, with *I-551 stamp or* attached *Form I-94* indicating unexpired employment authorization
5. Permanent Resident Card or Alien Registration Receipt Card with photograph *(Form I-151 or I-551)*
6. Unexpired Temporary Resident Card *(Form I-688)*
7. Unexpired Employment Authorization Card *(Form I-688A)*
8. Unexpired Reentry Permit *(Form I-327)*
9. Unexpired Refugee Travel Document *(Form 1-571)*
10. Unexpired Employment Authorization Document issued by DHS that contains a photograph *(Form I-688B)*

OR

LIST B

Documents that Establish Identity

1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card *(Form I-197)*
6. ID Card for use of Resident Citizen in the United States *(Form I-179)*
7. Unexpired employment authorization document issued by DHS *(other than those listed under List A)*

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Department of Veterans Affairs
Pacific Islands Health Care System
Honolulu, Hawai'i 96819

Facility Policy Memorandum
No. IRM-04-006
March 14, 2004

ATTACHMENT A

AUTOMATED INFORMATION SYSTEMS ACCESS AGREEMENT

As an authorized user of the Department of Veterans Affairs (VA), Automated Information Systems (AIS), I will be given access privileges to data, software, and hardware, to perform the duties of my job. AIS is defined as any computer system utilized by the VA to carry out its mission, to include, but not limited to, NT, VistA, CPRS, MS-EXCHANGE, BDN, networked computers, remote access computers, FORUM, CHCS, and Austin DPC. As an authorized AIS user of the Department of Veterans Affairs, VAPIHCS Honolulu, I agree, by my initialing in the spaces below, to the following:

____ All computers are, and remain the property of the Department of Veterans Affairs and are not to be used as my personal workstation. Access to this workstation may be given to other VA employees at the discretion of the VA.

____ As all workstations are the property of the VA, any of the contents of the disk drives are subject to examination by the VA as deemed necessary. Files of a highly sensitive nature should be stored on diskette or a network server.

____ I understand that I am responsible for reading the facility policies related to my use of automated information systems and to ensure the confidentiality, integrity, and availability of all electronic protected health information.

____ I am prohibited from loading any software onto any VA computer without the written permission of IRM and my supervisor.

____ I will safeguard all security codes given to me, including electronic signature codes, passwords, IDs, access, and/or verify codes. I will always log off of the NT system as well as VistA, CHCS, IDCU, etc., prior to leaving the area and at the end of the work day.

____ I acknowledge that I am strictly prohibited from disclosing my AIS passwords to anyone, for any reason and from allowing anyone else to use my passwords. I acknowledge that I am prohibited from using anyone else's passwords.

____ I understand that I will be held accountable for all work performed under my passwords.

____ I understand that as an employee, I have obligations to protect any information which the loss, misuse, unauthorized access to, or modifications of could adversely affect the conduct of federal programs.

____ I understand that all data to which I may obtain is now, and will remain the property of the Department of Veterans Affairs.

____ I may use network workstations for official duties only.

____ I understand that if I am granted access to the VA Intranet, Internet (World Wide Web), or E-Mail, I am to use it for official business purposes and will adhere to facility internet use policy.

____ I understand that use of the Internet is to be done in a manner that is consistent with the Department standards of business conduct and does not interfere with VA's mission or operations and is done as a part of the normal execution of my job responsibilities.

____ I understand that unless and until I am officially released in writing, all conditions and obligations imposed upon me by this agreement will apply.

____ I understand that I am responsible for ensuring that dual remote connections are not made through my personal PC especially if using cable modem when dialing into the VA.

____ I acknowledge that violations of this agreement will be an ADP Security Violation which will be reported to my supervisor, as well as the Information Security Officer, and that violations of this agreement may result in disciplinary action against me.

Signature: _____	Date Signed: _____	Print Title: _____
Print Name: _____	Print Service: _____	Phone: _____
Print Supr/ADPAC Name: _____		Phone: _____
Supr/ADPAC Signature: _____		Date Signed: _____

ATTACHMENT B

Department of
Veterans Affairs

MEMORANDUM

Date: _____

From: _____
Subj: Request for VHA LAN/VistA Access
To: IRM Service (IRM)

(Rev. 4/2004)

1. Name (print or type): Legal First Name	Middle Initial or NMI	Last Name
☐ New User (Vice:)	☐ Modify User:	☐ Terminate User
2. Job Series/Title: (e.g. Nurse, Fee Basis Physician, WOC, etc.)		3. Office Phone:
4. Employing Agency: (e.g. VHA, VBA, TAMC, etc.)		5. Work Site: (e.g. CFA, HRMS, Kauai CBOC)
6. DOB:	7. SSN:	8. Sex: M / F

9. Type of Access Needed:

☐ NT
☐ Exchange/Outlook
☐ Internet
* Remote Access contact the ISO.

☐ VistA/CPRS
Primary Template: _____
Secondary Menus: _____
Note: VistA Security Keys must be requested from the appropriate Applications Coordinator
☐ CHCS (Include Attachment D, TAMC Form 30)

Access Request Completed by:

Printed Name: _____

Title: (Circle) Supervisor / ADPAC Telephone Number: _____

Signature of Supervisor/ADPAC _____ Date: _____

Verification (to be completed by Service/Division Chief)

The above information is verified as correct.

Verified By: _____ Date Verified: _____

FOR IRM USE ONLY

ISO REVIEW: _____ Date: _____

IRM Processing

Completed By: _____ Date: _____

Rev. 4-2004